settlement fiscal periods.

6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges.

7. Calculate the amount of day outlier payments by:

a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE.

b. Sum the total days calculated in a. above for each FPE.

c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE.

d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c..

e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges.

f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days).

g. Relief is calculated by multiplying the result of 7. e. above by the result of 7. f. above.

8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:

a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $100 or $200 increments) in order to calculate the mean and standard deviation.

b. Calculate the mean charge per discharge and standard deviation for both FPEs.

c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE.

d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge.

e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge.

f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report.

g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f..

h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above:
   (1) Last name and first initial.

   (2) Admission date.

   (3) Length of stay.

   (4) Charges.

   (5) Amount of charges over the threshold.

   (6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.

i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately).

j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above.

k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE.

l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above.

m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges.

n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services.

o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not qualify as day outliers. This cannot exceed the amount of the MIRL liability.

B. AAs for changes in labor costs shall be resolved in the following manner:

1) Relief from the SWI and EBI can be granted if, and only if, the basis is due to labor/benefit cost increases per discharge resulting from either the new adherence to existing requirements imposed by government regulations, rules, and/or statutes or the adherence to new requirements imposed by government regulations, rules, and/or statutes. This includes new rules and new adherence to rules imposed by the Joint Commission on Accreditation of Health Organizations. The adherence to the regulations, rules, and/or statutes must be necessary to legally render the provided services to Medi-Cal recipients.

2) The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of the

adherence to the requirements. Any request for relief will require the following:

(a) A summation of the governmental requirements necessitating the increase in labor costs;

(b) Additional hours and staff required to adhere to the governmental requirements. The request will specify:

1. The exact title(s) of the added staff;

2. The appropriate employee cost category; and

3. The number of hours and hourly rates for each added or deleted staff member.

(c) Source of the additional support, e.g., new hire or transferred from another employee classification; and

(d) The appropriate pages of the Medi-Cal cost report reflecting the additional costs associated with the increased hours.

3) A separate request shall be rendered for each affected cost center. The cost centers for appeal purposes shall be the exact same cost centers as disclosed in the provider's Medi-Cal cost report as audited by the Department. Relief may be granted only for those cost centers that incurred the expenses as the result of governmental requirements.

4) The Department shall evaluate the submitted data to determine any changes in the following areas for each effected cost center:

(a) Labor hours per discharge;

(b) Labor costs per discharge;

(c) Changes made in other employee classifications that resulted in labor cost increases or decreases.

5) The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any

other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements.

6) The only basis for relief under Section VII. of this Plan shall be:

   (a) Increased employee hours per discharge; or

   (b) The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses.

7) Requests for relief on the basis of increased patient acuity will be deferred to Section VII. A. of this Plan. Patient acuity or service intensity shall not be entertained under Section VII. B. of this Plan.

8) Relief sought on the basis of labor disputes shall not be granted. Labor disputes are inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties.

9) Relief shall not be granted under Section VII. B. of this Plan as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

C. The following steps will be used for calculating relief, if any, for any ARPDL issues not otherwise specified in this regulation:

1) The provider shall clearly identify the issue and estimated dollar amount of relief.

2) The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall not be accepted by the Department.

3) The provider shall calculate what reimbursement, if any, is already included in the ARPDL due to this issue (such as pass-throughs or case mix covering a new service) and shall also calculate any overlap between this and other AA issues.

4) The Department shall review and correct if necessary, the provider's calculations in steps 1) through 3) above.

5) The Department shall subtract any overlap with other issues from the amount determined in steps 1) through 3) above.

6) The Department shall determine if relief is "one-time" or "formula".

VIII. AA FORMAL APPEALS PROCESS

A. A provider may appeal the Department's decision on the AAR for a final PIRL settlement only. There shall be no appeal on an AAR for a tentative PIRL settlement. The appeal shall be filed and conducted in accordance with the applicable procedural requirements of the provisions of the Plan, except as modified by Section VIII., including the following:

1) The appeal shall be submitted within 30 days after notification of the Department's decision on the AAR,

2) The provider shall present its issues and evidence first at the hearing, as they shall have the burden of going forward.

3) The provider has the burden of proof of demonstrating by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

4) In order to demonstrate that it is entitled to relief from the PIRL and that the AA decision should be overturned, the provider has the burden of demonstrating by a preponderance of the evidence that the Department's AA decision is inconsistent with the applicable regulatory provisions and that the provider's alternative is consistent with the applicable regulatory provisions.

5) If the Department's AA decision is proved, by a preponderance of evidence, inconsistent with the applicable regulatory provisions, and the provider has not proved by a preponderance of the evidence that its position is consistent with the applicable regulatory provisions, then the Administrative Law Judge (ALJ) may fashion whatever relief is necessary to obtain consistency with the applicable regulatory provisions.

6) Items that are not subject to an AA as specified in Section VII. of this Plan, shall not be subject to appeal.

7) The provider shall be paid at the PIRL initially determined by the Department pending determination of a formal appeal.

8) Any underpayments, identified in the appeal decision, shall be repaid to the provider, together with interest computed at the legal rate of interest beginning the later of the date the payment is received by the Department or the date the appeal is formally accepted by the Department.

9) The evidence to be submitted by the provider at a formal appeal hearing that was not provided to the Department nor specifically and individually identified as available to the Department, during the AA process excluding oral testimony, must be submitted to the Department 30 days before the scheduled date of the hearing. The only exception, is when a hearing is scheduled within 45 days from the date notice is given. In this latter case, evidence must be submitted 15 days before the scheduled date of the hearing. Failure to submit this information within the specified time frames shall result in its exclusion from the formal appeal hearing and record.

10) Recalculation of the PIRL due to an appeal decision shall not give rise to any further appeal rights.

11) If results of an audit appeal of the cost report or any prior fiscal period PIRL, AA or appeal, change data used in the settlement fiscal period PIRL, the PIRL shall be recalculated. The recalculation shall not give rise to further appeal rights.

12) If an issue in an AAR is not accepted pursuant to Section VI. E. 2) and 3), the ALJ may only consider the evidence that was presented in the AAR and not any additional information or testimony. If the ALJ determines that the issue should have been accepted, the issue shall be remanded for a response to the merits.

13) Only those issues that were clearly identified in a timely filed AAR, including an estimated dollar amount for each issue may be accepted as issues on a formal appeal.

LX. PEER GROUPING

A. Hospital reimbursement shall, unless exempted from or modified by the provisions of this Part, be payable at no more than the 60th percentile aligned ARPD of the peer group to which the hospital is assigned by the Department. This limit is the Peer Group Rate Per Discharge Limitation (PGRPDL). The peer groups shall be based on a classification of hospitals as determined in the 1991 Hospital Peer Grouping Report (Appendix C) published by the Department, that combines individual hospitals in a unit on the basis of similar or common characteristics. The following peer group classifications will be used:

1) University Teaching Hospitals.

2) Major (non-university) Teaching Hospitals.

3) Large Teaching Emphasis Hospitals.

4) Medium/small Teaching Emphasis Hospitals.

5) Extremely Large Sized Hospital.

6) Large Sized Hospitals.

7) Moderately Sized Hospitals.

8) Medium Sized Hospitals.

9) Moderately Small Sized Hospitals.

10) Very Small Sized Hospitals.

11) Acute Psychiatric Hospitals.

12) Alcohol-Drug Rehabilitation Hospitals

13) Combination Psychiatric/Alcohol/Drug Rehabilitation Hospitals.

14) Psychiatric Health Facilities.

15) Psychiatric Teaching Hospitals.

16) Psychiatric Children's Hospitals.

17) Moderate Alcohol-Drug Rehabilitation Emphasis Hospitals.

18) Moderate Psychiatric Emphasis Hospitals.

19) State Hospital-Veterans Home.

20) State Hospital-Mental Health.

21) State Hospital-Developmental Services

22) Children's Hospitals.

23) Crippled Children's Hospitals.

24) Rehabilitation Hospitals.

25) Large Rehabilitation Emphasis Hospitals.

26) Respiratory Specialty Hospitals.

27) Student Health Centers.

28) Charitable Research Hospitals.

29) Rural Hospitals.

30) Specialty Teaching Hospitals.

31) Prepaid Health Plan-Psychiatric/Alcohol-Drug Rehabilitation Hospitals.

32) Prepaid health Plan-Teaching Emphasis.

33) Eye Hospitals.

34) Women Hospitals.

35) Dental/Outpatient Hospitals.

B. The Department may review and change the number and definitions of peer groups and the peer group placement of individual providers.

1) Providers shall be notified of all such reviews and resultant changes to the peer groups.

2) For purposes of peer group placement, license beds shall be average licensed beds excluding any beds in suspense in accordance with Section 1271.1 of the Health and Safety Code.

3) All peer group assignments will be for all FPEs between July 1st and June 30th for each fiscal year.

C. Providers exempted from application of the PGRPDL shall consist of new hospitals, rural hospitals, sole community hospitals, children's hospitals, crippled children's hospitals, charitable research hospitals, primary health service hospitals and hospitals in peer groups with less than five Medi-Cal providers.

D. Providers with less than 15 Medi-Cal discharges in any FPE that covers over 360 days, shall be exempt from the PGRPDL for that FPE.

E. The peer group 60th percentile ARPD for each July 1-June 30 FPE shall be calculated by:

1) Obtaining the ARPD for each provider for the FPE during the state's fiscal period (or use the latest available if one is not yet available for the selected time period).

2) Using actual or estimated rates of inflation, align the ARPD for each hospital to a July 1 to June 30 FPE.

3) Locating the 60th percentile, by multiplying 0.6 times one more than the number of ARPDs in the peer group.

4) Starting from the bottom of a list of ARPDs, ordered from the lowest ARPD at the bottom, up to the highest ARPD at the top, count up the number of ARPDs using the result of E. 3) above.

5) Interpolate if necessary.

F. The 60th percentile ARPD shall be updated quarterly.

G. Once a final PIRL settlement is issued for a provider, the 60th percentile ARPD established in that Providers FPE shall not change, even though the final PIRL settlement may be reissued as a "recalculated final PIRL settlement" as a result of any appeal as well as other reasons for recalculation.